II. SCHEDULE OF BENEFITS

PPO PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $400 $800	 $1,250 $2,500
Coinsurance After Deductible	10%	30%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Out-of-Pocket Maximum (includes deductibles and copays) Individual Family	 $4,500 $9,000	 $5,000 $10,000
Physician Office Visits Primary Care Physician	$25 copay	30% coinsurance, after deductible
Specialist (includes cardiologists, psychiatrists, dermatologists, podiatrist, etc.)	$50 copay	30% coinsurance, after deductible
Preventative Care Benefits (One annual exam per calendar year including blood screening, urine tests, chest x-ray, EKG & mammography)	No Charge	30% coinsurance, after deductible
Allergy Injections/Immunotherapy	10% coinsurance, after deductible	30% coinsurance, after deductible
Diagnostic Tests (X-Rays and blood tests)	10% coinsurance, after deductible	30% coinsurance, after deductible
Imaging Services (CT and MRI scans require prior authorization)	10% coinsurance, after deductible	30% coinsurance, after deductible
Ambulance	10% coinsurance, after deductible	10% coinsurance, after deductible
Emergency Room (waived if admitted)	$150 copay	$150 copay

PPO PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Urgent Care Center Services	$25 copay	$25 copay
Outpatient Surgery Center Facility	10% coinsurance, after deductible	30% coinsurance, after deductible
Physician & Surgeon Fees	10% coinsurance, after deductible	30% coinsurance, after deductible
Hospital Benefits Daily Hospital Room and Board, Semi Private and other allowable expenses	10% coinsurance, after deductible	30% coinsurance, after deductible
Mental and Substance Use Disorder Inpatient	10% coinsurance, after deductible	30% coinsurance, after deductible
Outpatient -Office	$25 copay	30% coinsurance, after deductible
-Facility	10% coinsurance, after deductible	30% coinsurance, after deductible
Maternity Services Prenatal and postnatal services	$25 copay	30% coinsurance, after deductible
All other hospital and physician services	10% coinsurance, after deductible	30% coinsurance, after deductible
Hospice Services	10% coinsurance, after deductible	30% coinsurance, after deductible
Home Health Care (Limited up to 100 visits per calendar year)	10% coinsurance, after deductible	30% coinsurance Only
Skilled Nursing Facility (Limited up to 60 days per calendar year)	10% coinsurance, after deductible	Not Covered

PPO PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Durable Medical Equipment (Total rental not to exceed purchase price)	10% coinsurance, after deductible	Not Covered
External Prosthetic Devices	10% coinsurance, after deductible	Not Covered
-Wigs, toupees or hair pieces (Limited up to 2 per diagnosis/course of treatment. Does not cover for the diagnosis of androgenic alopecia- male pattern baldness)	10% coinsurance, after deductible, up to a maximum of $350	Not Covered
Physical, Occupational and Speech Therapy (Limited to 30 visits each per calendar year)	10% coinsurance, after deductible	30% coinsurance, after deductible
Chiropractic Care	$25 copay	30% coinsurance, after deductible

PPO PLAN

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail 30-Day Supply		
Generic Drugs	$10 copay	Not Covered
Preferred Brand Name Drugs	$30 copay	Not Covered
Non-Preferred Brand Name Drugs	$60 copay	Not Covered
Specialty Drugs	10% coinsurance, up to $150 maximum	Not Covered
Mail-Order 90-Day Supply		
Generic Drugs	$20 copay	Not Covered
Preferred Brand Name Drugs	$60 copay	Not Covered
Non-Preferred Brand Name Drugs	$120 copay	Not Covered
Specialty Drugs	10% coinsurance, up to $300 maximum	Not Covered

IF YOU ELECT THESE BENEFITS:

Dental Benefits
Provided by Delta Dental- call 1-800-452-9310 for Customer Service
1-800-335-8265 for Providers in your area
(Delta-Ok)

You may also obtain information on their website at www.deltadentalnj.com

Vision Benefits
Provided by VSP- call 1-800-877-7195 for Customer Service

You may also obtain information on their website at www.vsp.com